HRET HIIN Spring 2019 Falls Delirium Sprint #3

June 6, 2019
11:00 a.m. – 12:00 p.m. CT
WELCOME AND INTRODUCTIONS

Radhika Parekh, MHA
Performance Improvement Coach, HRET
Hello, My Name is…

- Name
- Hospital/State Hospital Association
- City, State
AGENDA

- Welcome and Introductions
- Review deadlines
- Hospital pre-assessment responses
- Personalizing Care
- Patient Family Engagement
- The Power of Patient Stories
- Questions and Answers
- Bring it Home
Your HRET HIIN Falls Sprint Team

Radhika Parekh, MHA
Performance Improvement Coach
HRET

Jackie Conrad, RN, BS, MBA
Improvement Advisor
Cynosure

Kim Werkmeister, RN, BA, CPHQ, CPPS
Improvement Advisor
Cynosure

Tara Bristol Rouse, MA
Patient and Family Engagement Project Consultant
HRET
Poll Question

- Who is in the room?
  a) Quality Leaders
  b) Nurse Leader
  c) Bedside Nurse
  d) Rehabilitation Team Member
  e) Pharmacy Team Member
  f) Patient Family Engagement Advisor
  g) Other
Why Are We Here?

- To use quality improvement techniques to assess root causes and develop action for falls with injuries and engage patients and their family members in prevention.

- To learn from each other and peer mentors:
  - Falls Delirium Fishbowl Hospitals:
    - Boulder Community Health, CO
    - North Alabama Medical Center, AL
    - AdventHealth System, KS- TODAY!
  - CAH Falls Mentor Hospitals
    - St. Vincent Salem Jennings, IN
    - Livingston Healthcare, MT
    - Lakeland Community Hospital, AL- TODAY!

Decrease Harm from Falls and Immobility

Engagement

Delirium

Mobility
HRET HIIN Falls Sprint Webinar Schedule

- All times from 11:00-12:00p.m. CT

- Thursday, June 20: [register here](#) Family as intervention, hospital stories
Hospital Submission Deadlines

- Falls Process Improvement Discovery Tool
  - Due ASAP
  - Submit to Allied Association (SHA) lead
Allied Association Submission Deadline

- Coaching Guide
  - Due June 13
  - Submit to Radhika Parekh at rparekh@aha.org
Hospital Pre-Assessment Responses
Jackie Conrad, RN, BS, MBA
Improvement Advisor, Cynosure
Pre-Assessment Results

When establishing a fall/mobility safety plan for a patient, how is the plan determined?

Answered: 152  Skipped: 0

![Bar chart showing the results]

- By the fall risk score: 73.68%
- Care planning is based upon: 26.32%
Pre-Assessment Results

Are patients at high risk for injury (on anticoagulants or by the Age Bones Coagulation Surgery (ABCS) criteria) identified, and injury prevention strategies applied, i.e. floor mats, toileting supervision?

Answered: 152  Skipped: 0

- Yes: 49.34%
- No, but this is a future...: 32.24%
- No: 18.42%
Pre-Assessment Results

Do your units conduct unit safety huddles to discuss which patients are at risk for injury that shift?

Answered: 152  Skipped: 0

- Yes: 53.29%
- No: 20.39%
- No, but this is a future...: 26.32%
What did you discover?
Share hospital findings
Share a patient story
Personalizing Care

Jackie Conrad, RN, BS, MBA
Improvement Advisor, Cynosure
Are you treating a unique individual or a number?
Understanding Human & Organizational Science

- Each patient brings unique capabilities and limitations
- The key factor associated with falls is movement
  - Movement is important for the patient
  - Movement is restricted by the organization
Patients may be

- Overwhelmed, distracted, unreceptive due to illness
- Misunderstand and deny risk for fall
- Unable to wait for assistance
- Weak, unsteady

Patients must mobilize to go to the toilet

Patients want

- independence
- privacy
- freedom of movement
Prevent injury through risk mitigation

- Limit independence
- Limit mobilization
Polling Question:

What percent of the fall harms you reviewed were related to toileting?
- 75-100%
- 50-74%
- 25-49%
- Less than 25%
How safe is your environment?

Guide: Creating a Safe Environment to Prevent Toileting Related Injuries
How do we balance risk for harm with patient privacy and dignity when it comes to toileting in the hospital?
Toilet safety strategies

- What patients do you require to have toileting supervision?
  - High fall risk patients
  - High Fall Risk: 2 on Mobility or Mental Status on Hester Davis
  - Pts with bed/chair alarm: Fall Score of 8 on FRASS or a designated score of on one of the 4 elements: mental, emotional, toileting, hx of falls

- Levels of intervention
  - Hourly rounding with intentional toileting
  - Schedule for assistance to the toilet
  - Direct supervision while in the toilet room. What does that mean?
    - Visualization
    - Foot in the door
    - Arms length
    - Stay close to the door
Toilet Safety Strategies

- What helps to support safety trumps privacy for staff and patients?
  - Keep it top of mind, always
  - Need to Know Education that staff must sign off on
  - STOP signs in the patient’s room
  - Reinforcement from Management
Identify FALL and INJURY Risk and do something about it!

Which patients are more vulnerable for a fall and sustaining an injury in your organization?

• **ABCS Injury Risk Assessment**

| A | Age > 85 |
| B | Bones – history of fracture, bone disease, osteoporosis |
| C | Coagulation – on blood thinners or bleeding disorder |
| S | Surgery within current episode of care |
Injury prevention care planning

Floor Mats
Low Beds
Hip Protectors
Toileting program
Medication review

Fall and Injury Risk Screeing, Assessment, Intervention Algorithm
Fall Prevention Care Planning

Individualized Interventions

- Medication Review
- Urinary catheter or IV discontinuation
- Mobility aids and assistance with walking
- Assist with IV when walking
- Up in chair for meals with assistance
- Assistance to toilet as regular intervals
- Appropriate footwear
- More frequent rounding
- Family visitation
- Patient engagement in identifying risks, consequences of a fall and needed safety interventions
- Fall and injury risks noted on whiteboard

Fall TIPS© Tool

Fall Prevention Care Planning
Risk based care planning

Toileting
Mobility
Behavioral
Cognitive
Secondary Dx

Fall and Injury Risk Screening, Assessment, Intervention Algorithm
Communicating the Patients and the Plan

- Unit Safety Huddles
  - Who are we most concerned about?
  - Leader rounds post huddle
- Centralized boards
- Whiteboards
  - I am risk for a fall because……..
  - If I fall I could be injured because…….

<table>
<thead>
<tr>
<th>Activity Orders</th>
<th>Date: ____________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed activity:</td>
<td></td>
</tr>
<tr>
<td>Up in Chair:</td>
<td>___ x a day</td>
</tr>
<tr>
<td>Assistance to get up:</td>
<td>________</td>
</tr>
<tr>
<td>Walking:</td>
<td>____ x a day</td>
</tr>
<tr>
<td>Assistance to walk:</td>
<td>_________</td>
</tr>
<tr>
<td>Distance to walk each time:</td>
<td>______</td>
</tr>
<tr>
<td>Equipment:</td>
<td>___________</td>
</tr>
<tr>
<td>Assist to toilet schedule:</td>
<td>__________________</td>
</tr>
<tr>
<td>Notes:</td>
<td>___________________</td>
</tr>
</tbody>
</table>
A Peek at the Evidence

- Patients understand that fall prevention is important, but 50-88% believe it does not apply to them. (Twibell et al 2015, Sonnad et al 2014)

- When structured falls education is provided to cognitively intact patients, falls can be reduced significantly.

  - 20 minute formal fall education with medical oncology patients led to ZERO falls with patients receiving education while those not educated continued to fall at a rate of 18% (Li-Chi Huang, 2015)
  
  - 45 minute formal fall education with rehab patients resulted in a 45% reduction in falls in cognitively intact patients (Haines, 2011)
Bedside Signage to Engage Patients and Families

PREVENTING FALLS IN THE HOSPITAL

Anesthesia, medication, surgery and decreased mobility increase your chances of falling. Special precautions will help prevent fall-related complications, including increased pain, additional surgery, a longer hospital stay or extended recovery.

TIPS TO AVOID A FALL

- Ask for assistance before getting out of bed—every time.
- Use the call light when you need assistance of any kind.
- Use the bedbell often to avoid "emergencies." Always ask for staff assistance. Do not get up from the toilet without assistance.
- Take your time when sitting, standing up or lying down. Let your nurse know if you feel dizzy or lightheaded.
- Wear loose-fitting or loose-fitting clothes, or supportive shoes at all times.
- Avoid long-nightgowns and robes.
- Use a walking aid/back or a walker. Staff may use safety devices, such as a call bell, to assist you.
- Wear your glasses and hearing aid, if applicable.
- Use only stable objects to steady yourself; never use an IV pole, tray table or wheelchair for this purpose.
- Let staff know if there is a spill or slippery spot on the floor.
- Ask your nurse what activities you can perform on your own.
- Keep important items—call light, phone, glasses—within easy reach.

WHAT FAMILY MEMBERS CAN DO:

- Wait for staff to assist your loved one.
- Help keep the room free of clutter.
- Share your safety concerns with the nursing staff.
- Leave safety alarm settings alone (as set).
- Before leaving the room, make sure:
  - The bed is in the low position with side rails up.
  - The call light and bedside table are within easy reach.

CALL Press call button for nurse
Don’t fall Get help before getting up

NONSLIP SOCKS

GAIT BELT

Lutheran Fall Questionnaire

I’m at risk for a fall because...........

I could be injured if I fall because...........

Activity orders:

How much assistance:

Assistive Device:

Check Your Risk of Falling

Circle yes or no for each statement below:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am in a new, unfamiliar environment.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>I am weaker than usual.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>I am having trouble with balance.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>I am on medication for pain.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>I have had a recent fall.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>I have recently been instructed to use assistive devices.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>I need to walk with my hands to stand up from a chair.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>I have lost some feeling in my legs or feet.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>I take medications that sometimes makes me feel tired, lightheaded or weak.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>I take medication to help me sleep or improve my sleep.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>I have behavioral or emotional issues or have periods of inattention or disorientation.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>I am currently eating or drinking less than usual.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>I take medication for depression.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>I have a pressure-reduction mattress.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>I have a trachea or compression devices.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>I tend to move very quickly.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>I don’t like to bother the staff, I can do it myself.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>I tend to walk in my wheelchair to pick up items off the floor.</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Why it matters:

- Being in a new, unfamiliar environment increases risk for falls.
- Not being as strong as you expect increases risk for falls.
- Guarding against pain can affect balance.
- Pain medication can cause sedation and dizziness.
- People who have fallen once are likely to fall again.
- Improper use of new devices increases risk for fall.
- Periods of inanition increase risk for fall.
- Using furniture for support is not always reliable.
- The increase the chance of instability and falls.
- Risking decreases awareness of environment and safety practices.
- Lost feeling in the legs or feet decreases stability.
- Sedation, lightheadedness and weakness increase potential for fall.
- This may cause sedation, dizziness or weakness.
- This may increase the chance of visual impairment in judging stable footing.
- Dehydration and low blood sugar can cause weakness and dizziness.
- Prolonged use of blood sugar can cause weakness and dizziness.
- Sitting too close to the edge of the mattress can cause a fall.
- Being tethered to a device while walking can affect balance.
- Impulsive movement can decrease stability.
- Not asking for help when needed increases chances for falls.
- Seducing forward in a wheelchair can cause it to tip over.

I acknowledge that I have read and understand the education provided on how I can help prevent myself or my loved one from falling.

[Signature]

Lutheran Health Network

LH9/18/17

American Association for Hospital Accreditation

Advancing Health in America

AHA CENTER FOR HEALTH INNOVATION
Voices from the field...the power of patient stories

Dorothy Rice, Director of Quality

Winter Falls Delirium Fishbowl Hospital

AdventHealth Ottawa, KS
Patient and Family Engagement (PFE)
Tara Bristol Rouse, MA
HRET HIIN PFE Project Consultant
It’s All Patient and Family Engagement
# Ensuring Multi Level Patient and Family Engagement (PFE)

## Falls

### Change Ideas

<table>
<thead>
<tr>
<th>Metric 1</th>
<th>Metric 2</th>
<th>Metric 3</th>
<th>Metric 4</th>
<th>Metric 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Point of Care</strong></td>
<td><strong>Policy &amp; Protocol</strong></td>
<td><strong>Governance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implementation Partners: Point of Care Providers, Medical Directors, Nurse Managers</td>
<td>Implementation Partners: Quality and Safety Leaders, Medical Directors, Nurse Managers, Patient Experience Leaders</td>
<td>Implementation Partners: Board of Directors, C-Suite</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Point of Care

- At the pre-op appointment, provide the patient/family with a copy of the tool, **Staying Active in the Hospital**. Review key points regarding what to expect and the important role they have in early mobility.

- Post the **Let’s Get Moving** chart next to the patient white board. Introduce it to the patient and family and ask them to track progress. During daily rounds, ask patient/family to report progress and any challenges they have experienced.

### Policy & Protocol

- As part of his/her nursing clinical ladder program, ask a nurse to audit patient mobility charts to determine how many patients/family members are using the charts and whether their activities are aligning with agreed upon daily mobility goals.

- Engage your PFAC to review and redesign the **Let’s Get Moving** tool so that it is personalized to your hospital and target population. Keep what they like about the tool and use their feedback to improve the areas they feel should be changed.

### Governance

- Invite family caregivers to attend a Board meeting. Ask them to discuss the role they play in early mobility and have them outline the inpatient equipment required so that they, along with the staff, can assist their loved one without causing injury to themselves or the patient.
Resources

ICUdelirium.org-patientfamilyoverview
### Who I Am

Being in an unfamiliar environment can be unsettling. The information collected within this form will provide the healthcare team with a better understanding of your loved one’s needs.

This form should be completed by the individual who knows the person best and, when possible, with their loved one. This is not a medical document. It is meant to support the healthcare team in providing the best care possible.

#### Patient Name:

<table>
<thead>
<tr>
<th>Name I prefer to be called:</th>
<th>Normal Routine (grooming/bathing time):</th>
</tr>
</thead>
<tbody>
<tr>
<td>People that are important to me:</td>
<td>Meal Times:</td>
</tr>
<tr>
<td>Who helps care for me:</td>
<td>Food likes:</td>
</tr>
<tr>
<td>My pet’s name:</td>
<td>Food dislikes:</td>
</tr>
<tr>
<td>What I do/for a living/school I attend:</td>
<td>Sleep Time:</td>
</tr>
<tr>
<td>Hobbies:</td>
<td>How I like to take my medications:</td>
</tr>
<tr>
<td>Fond memory:</td>
<td>I am most alert in the:</td>
</tr>
<tr>
<td>Likes (music, TV, smells, etc.):</td>
<td>❑ Morning ❑ Afternoon ❑ Evening ❑ Night</td>
</tr>
<tr>
<td>Dislikes:</td>
<td>What upsets me:</td>
</tr>
<tr>
<td>Equipment I use regularly:</td>
<td>What calms me down:</td>
</tr>
<tr>
<td>❑ Cane ❑ Walker ❑ Wheelchair</td>
<td>I am: ❑ Right handed ❑ Left handed</td>
</tr>
<tr>
<td>❑ Other:</td>
<td>Anything else I want you to know:</td>
</tr>
</tbody>
</table>

I agree that the information on this form may be shared with the healthcare team.

Form Completed By: ____________________________
Date Completed: ____________________________

NOT A PART OF THE PERMANENT MEDICAL RECORD
What to STOP doing to START Improving Falls

Fresh Thinking about Mobility

Thought Provoking Articles
- False Bed Alarms a Teachable Moment
- The Tension Between Promoting Mobility and Preventing Falls in the Hospital
- The Frances Healey Reader: Key ideas and references
Patient and Family Engagement Tools

- Teach Back Tool for Fall Prevention
- Teach Back Event Recording
- Fall Tips for Patient and Families Handout
- Patient Agreements:
  - Intermountain Health Patient Agreement
  - Cox Health Fall Prevention Partnership
Do you have a patient story to share?
THANK YOU!